



EDS Customer Assistance Unit

Customer Assistance Operating Procedures Manual

LIBRARY REFERENCE NUMBER: PA10002

REVISION DATE: February 2005

VERSION 2.0



Customer Assistance Operating Procedures Manual

Library Reference Number: PA10002

Document Management System Reference: Customer Assistance Operating Procedures
Manual

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	December 2000	All	New Document	Z. R. Davis
Version 2.0	February 2005	All	Updated	Publications

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Section 1: Introduction

Overview

The Indiana Health Coverage Programs (IHCP) was established to provide medical assistance to eligible Indiana residents. The IHCP includes the following programs and delivery systems:

- 590 Program – A State Health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
- Traditional Medicaid – Provides services to aged, blind, and disabled IHCP members.
 - Standard Plan – IHCP members enrolled in the Traditional Medicaid – Standard plan are eligible for *full coverage*.
 - Spend-down – Spend-down is similar to a deductible in that the member must incur medical expenses in the amount of their excess income each month before becoming eligible for Traditional Medicaid.
 - Waiver – Waiver services are used to prevent institutionalization of the member. A specific waiver service is to be provided only when a member cannot meet the particular unassisted need.
 - QMB (Qualified Medicare Beneficiary) – Traditional Medicaid pays Medicare deductibles, coinsurance, and the Part B premium.
- Hoosier Healthwise Benefit Packages
 - Package A – Standard Plan – Full coverage for children, low-income families, and some pregnant women.
 - Package B – Pregnancy Coverage Only – Pregnancy-related and urgent care for some pregnant women.
 - Package C – Children’s Health Plan – Preventive; primary and acute care services for some children under 19 years old.
 - Package E – Emergency Services Only – IHCP members enrolled in this package are eligible for emergency services only.

Delivery Systems

- Fee For Service
- *Medicaid Select* – PCCM
- PCCM
- RBMC

EDS is responsible for administering IHCP for the Office of Medicaid Policy and Planning (OMPP). This manual outlines the responsibilities of the EDS Customer Assistance Unit. EDS is committed to superior customer service and achieves this by extensive and comprehensive training programs, an aggressive strategy toward problem resolution, and continually monitoring performance standards.

The Customer Assistance Unit is divided into three areas: Customer Inquiry lines, Member Hotline, and Provider Enrollment lines. The Customer Assistance Inquiry Unit includes telephone customer assistance (CA) analysts and a supervisor(s). The CA analysts receive telephone calls from providers and IHCP members who use both local telephone and toll free telephone numbers. Claim status,

checkwrite information, provider enrollment, proper billing procedures, and prior authorization (PA) inquiries are examples of the types of inquiries addressed by Customer Assistance.

Goals and Objectives

Quality customer service is imperative to the success of the IHCP. The mission of the EDS Customer Assistance Unit is to deliver superior customer service to providers and IHCP members in a courteous and professional manner. The Customer Assistance Unit maintains quality service by focusing on three areas: continuous training, internal quality control, and internal communication.

The Customer Assistance supervisor, with the direction of the Member and Provider Relations Director, maintains a training program that supports this mission. In addition to a formal training program for new employees, continuing education in areas such as billing procedures and policy updates from the OMPP and provider enrollment ensure that staff remain updated. The result is timely and accurate answers to questions from the providers and IHCP members. Formal training includes extensive study of the *IHCP Provider Manual*, *IndianaAIM*, Automated Voice Response System (AVR), the Indiana Medicaid Web site, and reports and reference materials used in daily operations.

Customer Assistance personnel maintain rigid performance standards. EDS maintains a sufficient number of telephone lines and personnel to staff the lines so that no more than five percent of the incoming calls receive a busy signal or are on hold for more than 120 seconds. The supervisor monitors individual production using automated reports and online verification of quality standards. Continuous feedback from leadership to staff ensures accuracy and professionalism when responding to provider and member inquiries. Production standards are set by the type of splits (a type of call such as a claim inquiry or covered service question) each CA analyst answers and the number of calls presented to each split on a daily basis. After the first 90 days of employment, CA analysts are expected to maintain daily production goals and meet contractual required response times daily upon training completion.

The Customer Assistance Unit closely interacts with the Provider Relations staff, Provider Enrollment staff, and Written Correspondence staff to resolve training issues and concerns within the provider and member communities. The unit also acts as an intermediary between the providers, IHCP members, and other EDS units, by resolving billing or adjudication problems requiring additional information or research by other departments.

Section 2: Organization, Staffing, and Training

Introduction

This section includes a description of each Customer Assistance Unit position within the Member and Provider Relations Unit. The EDS Customer Assistance Unit responds to provider and member inquiries from 8 a.m. to noon and 1 p.m. to 5 p.m. Indianapolis area local time, Monday through Friday, excluding State holidays. The Customer Assistance Unit is also unavailable between noon and 1 p.m. Monday through Friday.

Customer Assistance Organization

Customer Assistance Supervisor

The customer assistance supervisor position oversees the activities of the CA analysts for the Indiana Title XIX program. The supervisor works closely with the OMPP to ensure contractual obligations are met and assists CA analysts with resolution of billing and claim discrepancies. Development of trend CA analyst of calls is required to support the continual improvement. Additional responsibilities include updating written responses in the Action Calendar, Monthly Status Report, State Fiscal Year Quarterly Report, Business Plan, Training Plan, and Customer Service Plan.

Customer Assistance Trainer

The customer assistance trainer is responsible for improving the Customer Assistance Unit's ability to serve its customers: the OMPP, providers, and IHCP members. The customer assistance trainer provides formal training to all customer assistance staff in the customer service concepts, applications, and IHCP programs and policies. The customer assistance trainer works with other unit's subject matter experts (SME) to coordinate training to the customer assistance staff. This position promotes the continuous commitment to providing quality customer service.

Customer Assistance Analyst

The CA analyst provides timely, accurate, and courteous responses to providers and IHCP members concerning claims status, eligibility, and general billing information. The CA analyst must maintain daily production goals and meet contract required response times. In addition, the CA analyst performs other duties as required to support the unit and the account.

Training

EDS employees meet all the requirements outlined in the job description. The customer assistance supervisor interviews potential candidates. The Member and Provider Relations director reviews the final candidates before an offer of employment is made to the candidate.

Knowledgeable staff is critical to providing superior service to providers and IHCP members. The customer assistance supervisor is responsible for presenting a comprehensive training program, which

includes all aspects of the IHCP and the policies that govern the providers. The tools used for training include the *Customer Assistance Operations Manual*, the *IHCP Provider Manual*, banner pages, bulletins, newsletters, all IHCP supplemental manuals, resolution manual, and reports and reference materials used in daily operations. Another training tool used is rotation through other areas such as mailroom, data entry, resolution, adjustments and the provider relations staff. On State holidays when EDS is open, all CA analyst attend a full day training session. These full day training sessions are planned in advance using a comprehensive training agenda. The subject matter varies from improving the customer skills to refreshers on how claims are processed. Training materials and agendas can be found online at L:\Client Services\CS CA Repository\Training.

The customer assistance supervisor is responsible for reviewing policy updates, system changes, and any issues identified by CA analysts during weekly staff meetings. Consistency between CA analysts is accomplished by weekly supervisor meetings, daily interaction between the supervisor, and review of each CA analyst's phone inquiry statistics.

The customer assistance trainer is responsible for reviewing policy updates, system changes, and any issues identified by CA analysts. Weekly staff meetings are held between the Member and Provider Relations director and the various units within the Member and Provider Relations Department. These units include the Customer Assistance Unit, the Written Correspondence Unit, and the Provider Relations Unit.

Performance Management Program (Employee Development)

EDS is committed to developing employees and providing continuous improvement feedback.

- Annual Objectives: Distributed to each employee at the start of the year and updated as necessary.
- Individual Development Plan: Document career-goals, interests, objectives, and development areas with development plans.
- Annual Formal Assessment: Annual review of performance objectives, skills, competencies and objectives are assessed.
- Quarterly Performance Management Program (PMP) Sessions: Schedule meeting with employee and leader to review performance, individual development and objectives. Identify status or need for additional training requirements.

Section 3: Work Flow Procedures

Overview

The CA analysts receive calls from providers through toll-free and local telephone numbers. Calls are routed to an available CA analyst by an automated call distribution system provided with the Avaya Definity G3SI telephone system. Figure 3.1 is the workflow for the telephone system.

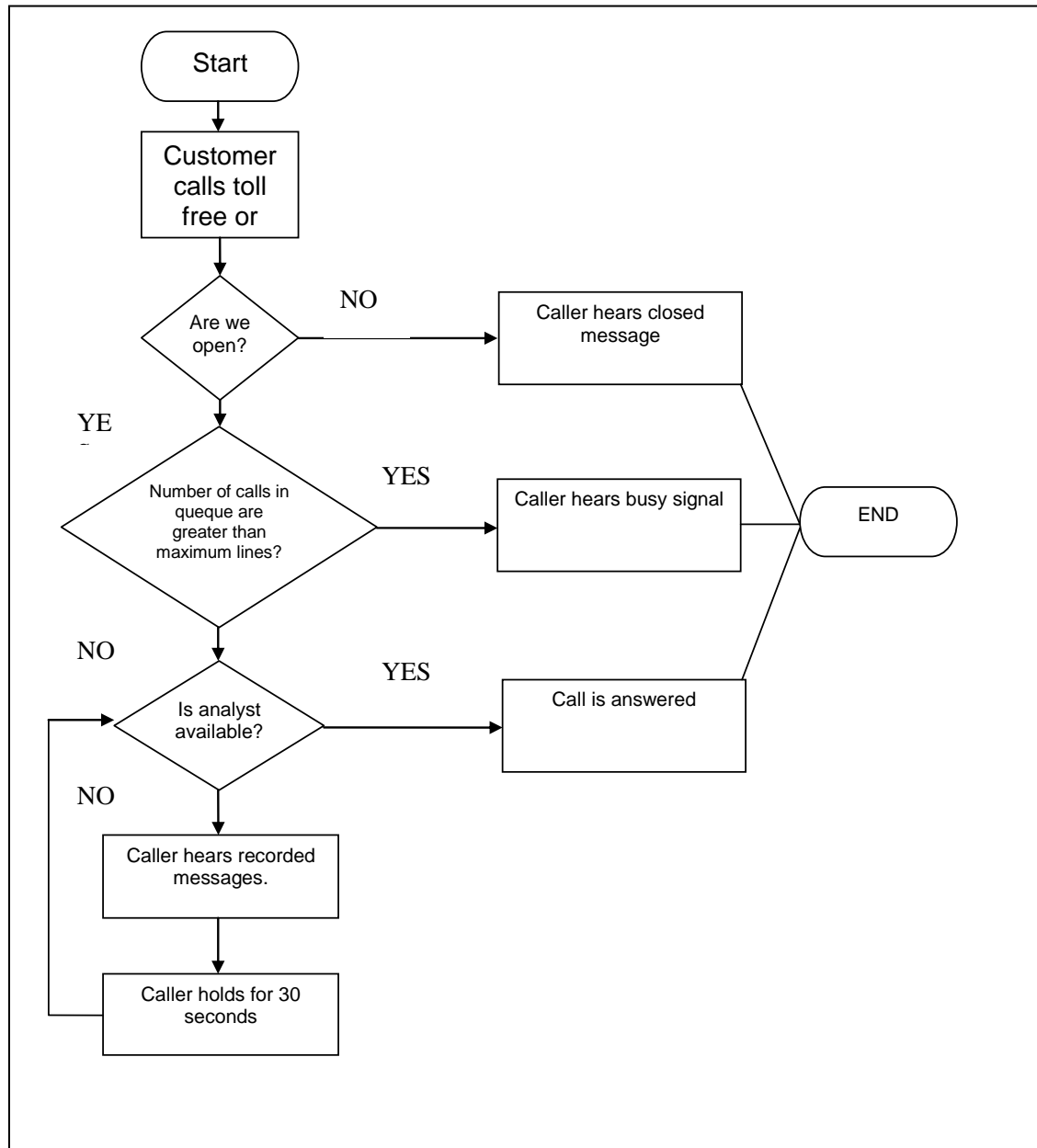


Figure 3.1 – Call Management System Workflow

Customer Assistance Analyst Procedures

When answering a call, the CA analyst uses the *Provider Phone Tracking Window Log (PTL)* to document each telephone inquiry. The majority of provider inquiries are resolved immediately. The CA analyst provides an answer to the inquiry and enters the call type into the PTL. However, some calls require that forms be completed and routed to another department.

Some calls require research that prevents an immediate response. If additional research is necessary, the provider is told when a callback should be expected, and the inquiry is documented. The CA analyst performs the necessary research, completes the appropriate form, calls the provider back and completes the inquiry.

In cases where the provider is not satisfied with the inquiry response or the CA analyst needs additional help in researching the inquiry, the CA analyst alerts the customer assistance supervisor. The supervisor addresses the inquiry with the CA analyst, assists the CA analyst in answering the inquiry, or performs the callback for the CA analyst.

All callbacks must be completed within three business days. The customer assistance supervisor verifies that all provider callbacks are made when the necessary research is completed. To ensure all open issues are resolved, calls are logged as incomplete in the PTL and reported on *PRV-8028-M*.

CA analysts promptly and accurately respond to telephone inquiries using many tools. Each CA analyst is provided with a single unit telephone and a hands-free headset. Also provided is a workstation complete with personal computer, and several manuals including the *IHCP Provider Manual*. CA analyst may also access the Indiana Medicaid Web site.

The primary reference manual used by the CA analyst is the *IHCP Provider Manual*. This manual is used by providers for reference, information on provider enrollment, policy information, and claim billing procedures.

In addition to these items, various manuals and reports are supplied to each CA analyst.

Inquiry Types Received in Customer Assistance

Claim Status

The CA analyst obtains the status of a claim by entering the member's identification number, the billing provider's identification number, the internal control number (ICN), the date of the remittance advice, or the date of service into *IndianaAIM*. The CA analyst determines if the claim has been paid, has been denied, or is pending. If the claim has been paid, the CA analyst informs the provider the date paid, the amount paid, and an explanation of any unpaid charges. A denied or pending claim is identified by the CA analyst, along with an explanation for the denial or suspense. If appropriate, the CA analyst provides instructions for rebilling the claim.

Eligibility Inquiry

Although CA analysts are not responsible for verifying member eligibility, they may assist providers with member eligibility claim denials. When a provider has received a claim denial pertaining to a member's eligibility, the CA analyst accesses the member eligibility windows in *IndianaAIM* to identify the correct eligibility information for the provider. Eligibility verification may also be obtained by using one of the following methods:

Automated Voice Response system	The AVR system provides a toll free telephone number to help providers obtain pertinent information about member eligibility, third party liability (TPL), benefit limitation, checkwrite, and PA. The system is accessible by dialing (317) 692-0819 in the Indianapolis local area or 1-800-738-6770, and is available seven days a week between 5 a.m. and 1 a.m., EST, (Indianapolis local time). Using the RID number, the member's Social Security number, or the member's Medicare number and the date of service may access information.
Web interChange	Web interChange is a Web application used to inquire about claims, member eligibility, and payment information. Web interChange is a secure site with user identification numbers (ID), passwords, and data encryption to safeguard sensitive information. Access to Web interChange is free of charge to all IHCP providers who have Internet connectivity.
Eligibility Verification System (EVS) Using the OMNI Terminal Device	The OMNI terminal device takes advantage of the member identification card and allows easy eligibility determination by providers at the time of service. The OMNI technology is common in other business areas such as bank charge cards, where they provide ease of use and almost immediate confirmation of eligibility to purchase. The same principle governs eligibility verification for services to IHCP members. OMNI eligibility verification is available from 5 a.m. to 1 a.m., EST (Indianapolis local time), seven days a week. The system may also be accessed by using the recipient identification (RID) number, the member's social security number, or the member's Medicare number, along with the date of service.

Provider Enrollment Inquiry

All providers rendering services to eligible IHCP members must be enrolled in at least one of the IHCP programs to receive payment. Each provider is assigned a provider identification number that must be recorded on each claim processed by EDS. Participating providers, as well as providers currently involved in the enrollment process may use the EDS customer assistance telephone inquiry to access enrollment information. Enrollment and expiration date, address information, program involvement, and checkwrite information are examples of enrollment information researched by the CA analyst. If a provider has submitted an application for enrollment in one of the programs, the CA analyst accesses enrollment status information by entering the provider's name in the Provider Enrollment Tracking System.

Third Party Liability

The CA analyst provides information about the IHCP member's TPL or other insurance. The name and address of the primary insurance company, and policy information such as name of the policyholder, policy identification number, and effective dates of the policy are examples of information provided in a telephone inquiry. In some instances, providers may be referred to the TPL Unit. For example, if the provider has a letter from a primary insurance company stating the policy has been terminated; a copy of this letter should be mailed directly to the TPL Unit to update the member's file.

Billing Instructions

CA analysts are trained in proper billing procedures for all IHCP claim types. Each CA analyst has access to the *IHCP Provider Manual*. The *IHCP Provider Manual*, chapter 8, outlines general and specific billing procedures. If a provider needs assistance or has submitted a claim that has been denied due to improper billing procedures, the CA analyst determines the problem and explains the correct billing process. The CA analyst refers the provider to the applicable section and page of the

IHCP Provider Manual. Familiarizing the provider with this resource helps ensure proper billing procedures and expeditious claim processing.

Stop-Pay and Reissue Check Request

A provider may contact a CA analyst to request stop payment on a check written by EDS. This request is usually initiated for one of the following reasons:

- The provider has the lost check
- The provider believes the check was stolen
- The provider has not received the check through the US mail
- The provider has received their remittance advice (RA) without an enclosed check

Member Hotline

Enrolled IHCP members may call the Member Hotline. CA analysts answer inquiries such as eligibility, bills received, covered services, and benefit information. The CA analysts respond to all categories of calls, provide referrals to various programs, and educate IHCP members about benefits of the various programs.

Online Screens

The Customer Assistance Unit has access to most online windows in *IndianaAIM*. The windows referred to throughout this manual are documented in the systems documentation manuals.

CA analysts access online windows to respond to provider and member inquiries. In addition to claim history information, CA analysts can access member, provider, prior authorization, TPL, and reference information. Window capabilities allow the CA analysts to access multiple applications simultaneously. Refer to the appropriate systems documentation for information about screen access, edits and function.

A 36-month claim history is accessible via the Claims Inquiry window. The CA analyst may request a history of claims using the member identification number (RID), the provider identification number, or the internal control number (ICN). Within those parameters, the CA analyst may select claims based on claim status, claim type, or dates of service. The CA analyst can also print the information contained in the window. Available information includes date of service, procedure, or service rendered, charge amount, allowed amount, paid amount, date paid or denied, and all payment or denial codes.

Section 4: Special Information

Provider Reimbursement Profile

This section provides information about the reimbursement methods used by the IHCP. In addition, several specific reimbursement issues are discussed.

Diagnosis-Related Grouping

Diagnosis-related groups (DRG) are used to reimburse inpatient hospital claims. This method groups diagnosis codes into related groups. Each DRG has an assigned reimbursement amount regardless of the number of days or supplies used during the inpatient stay. The principal diagnosis code, principal surgical procedure code, secondary diagnosis code, secondary procedure code, patient status, and member's age, and gender are used to group the claim into one of the established DRGs.

If the system cannot place the claim into one of the established DRGs, for example, an extended stay for psychiatric care, it assigns a DRG with a base-rate of zero. The zero base-rate forces the claim to level of care pricing. Levels of care include:

- Psychiatric unit
- Rehabilitation unit
- Burn unit

Levels of care claims are paid at a *per diem* rate. The hospital is paid a set amount of money for each day the member remains an inpatient. The *per diem* rate includes all services provided to the member.

Outpatient

The outpatient pricing method calculates the IHCP allowed amount based on the appropriate pricing method for the date of service. Effective March 1, 1994, outpatient services are reimbursed either by the surgical code submitted on the claim or a flat rate if no surgery is performed. Separate rates apply depending on whether the service provided to the member was an emergency or a routine procedure. Copayments may apply in certain circumstances.

Laboratory

The laboratory pricing method calculates the IHCP allowed amount for laboratory services based on the Healthcare Common Procedure Coding System (HCPCS) procedure code reported on the claim.

Maximum Fee

Effective January 1, 1994, physicians and other medical practitioners are subject to the maximum fee (max fee) pricing method. Providers are reimbursed the lower of the submitted charge or the statewide maximum fee schedule established by the OMPP.

Normal

The system pays the least of usual and customary charge, prevailing charge, max fee, or the submitted charge.

Manual Pricing

This indicator applies to procedures that require individual consideration. The system suspends every procedure code with a pricing indicator of five for manual review.

Transportation

This indicator directs the system to use the transportation pricing logic.

Crossover Claim

The pricing method is retroactive. All crossover claims priced since the inception of the IndianaAIM on February 6, 1995, are adjusted to reflect the new pricing method.

Pharmacy Claim

The system reads the classification on the drug file to determine if a drug is a legend or non-legend drug.

Anesthesia Claim

The anesthesia pricing function obtains the necessary information from the CMS-1500 claim form. The system applies the anesthesia pricing logic for anesthesia, medical direction, and certified registered nurse anesthetist (CRNA) details.

Resource-Based Relative Value Scale

Since October 6, 1994, the resource-based relative value scale (RBRVS) has been used as the provider fee schedule for physicians, limited license practitioners, and other non-physician medical practitioners. Providers are reimbursed at the lower of their submitted charge or the established statewide RBRVS fee schedule for the procedure. The RBRVS fee is based on the Medicare relative value unit multiplied by the conversion factor for the procedure as established by the OMPP.

RBRVS was designed to represent the resource costs associated with the provision of physician services for a more equitable reimbursement structure. RBRVS incorporates the following three components of physician services:

- Physician work – Measured by the time and intensity of the physician's effort in providing a service.
- Practice expense – Includes items such as office rent, salaries, equipment, and supplies.
- Malpractice expense – Measured by professional liability premium expenses.

Services are reimbursed using the Indiana RBRVS Fee Schedule that meets the following criteria:

- Current Procedure Terminology (CPT) code is used for the service, or the service can be linked to an existing CPT code
- The service is included in the Medicare Fee Schedule
- Relative value units exist for the service or have been developed for the service
- The procedure is covered by IHCP.

Indiana Family and Social Services Administration (IFSSA) determines the reimbursement for valid CPT codes if Medicare relative values studies (RVU) are not appropriate, or not available, using a maximum fee schedule method of reimbursement or by manually pricing the claim.

The *IHCP Provider Manual* gives specific, detailed information about provider reimbursement. The *Pricing Users Manual* provides pricing logic.

Reference Library

The Customer Assistance Unit maintains a hard copy reference library to supplement the online reference windows in IndianaAIM. The majority of the library is devoted to reference manuals containing procedure and diagnosis codes. The IHCP use the HCPCS for billing. This section contains an overview of the HCPCS coding system and a list of reference tools with a brief description of the contents.

Current Procedural Terminology

The first level of HCPCS is the American Medical Association's CPT coding system. The system is documented in the CPT handbook and is updated annually. The CPT handbook lists more than 7,000 codes describing procedures and services performed by physicians. The codes listed in the CPT manual consist of five digits. For example, 99214, is the CPT code for an office or outpatient visit. The CPT system also contains several numeric modifiers. As an example, -22, is the CPT modifier for unusual services.

National Codes

Centers for Medicare & Medicaid Services (CMS) created the National Codes as a supplement to CPT. The National Codes manual lists more than 2,600 codes for supplies, services and procedures not contained in the CPT handbook, but which may be covered by assistance programs such as the IHCP. Most of the codes in the National Codes system are for durable medical equipment (DME), prosthetics, orthotics, ambulance services, dentistry, and others. Like the CPT codes, the National Codes are updated annually. IHCP requires that physicians use the National Codes for reporting services and supplies not listed in the CPT manual.

National codes are alphanumeric, and start with a letter of the alphabet followed by four numbers.

When to use National Codes

CMS created the National Codes both as a means of reporting supplies and services not listed in the CPT manual and as a means of reporting services, such as injections, more specifically than allowed by CPT codes. For practical purposes, the majority of codes reported to the IHCP are CPT codes.

However, the IHCP does not always accept the supply codes and specific codes listed in the CPT manual. Instead, the use of National Codes is required.

International Classification of Diseases – Clinical Modification

The International Classification of Diseases – Clinical Modification (ICD-9-CM) manual contains medical diagnosis codes and their definitions.

Medical Terminology Dictionary

The medical terminology dictionary functions as any other dictionary. The contents of the dictionary are medical related.

IHCP Provider Manual

This manual is the provider reference guide to provider enrollment, policy information, and IHCP claims billing.

Section 5: Reports

Overview

Table 5.1 lists the reports used by the Customer Assistance Unit for daily operational procedures:

Table 5.1 – Customer Assistance Reports

Report Number	Report Name
CLM-0109-W	Indiana Family & Social Services Administration Remittance Advice
CRA-0005-W	Provider Remittance Advice
PRV-8028-M	Monthly Phone Tracking Report
N/A	CentreVu Supervisor Version 6 Reports
Various	Monthly Status Report

Remittance Advice

IHCP providers receive a weekly remittance advice (RA). The RA identifies claims that have been paid, denied, or are pending. The RA includes the RID number, the provider number, the ICN number of the claim processed, and the date of service. In addition, each claim detail has a message code that explains the reason for payment, denial, or pending status. RAs are tailored to individual provider types and may include additional information where appropriate, such as procedure code, HCPCS code, revenue code, or admission and discharge date for providers who bill on the UB-92 claim form.

Claims Correction Forms (CCF) are included with some RAs containing pended claims. These forms are system-generated when a claim has been edited for a data error. The provider is responsible for entering the correct information on the CCF, and returning it within 45 days of receipt, or the claim will be denied.

CA analysts can access copies of the RAs using *OnDemand*. By accessing *OnDemand*, the CA analyst can determine the status of a claim, and the appropriate avenues of resolution. The CA analyst encourages providers to have the RA available when inquiring about pending or denied claims.

Description of Information on the Provider/Member Phone Tracking Report

This report summarizes the total number of inquiries per inquiry type received by the Customer Assistance Unit for the stated time period. These reports also summarize the number of unique providers accessing the Customer Assistance Unit, and the total number of complete and incomplete inquiries during the stated time period. These reports list all open status inquiries by provider or member number. The ten providers who called the Customer Assistance telephone number most are listed with the corresponding number of inquiries made during the reporting period. This information may be used to target specific providers who may require additional training or attention.

Purpose of Report

The purpose of this report is to monitor providers that may be experiencing billing problems and to identify the types of calls received in the Customer Assistance Unit.

CentreVu Supervisor Report Examples

This system provides reports that reflect individual and group telephone line activity. The CMS reports are generated daily, weekly, and monthly to provide the following types of information:

- Automated Call Distribution (ACD) activity by each hour of the work day
- Number of calls received
- Average answering speed for each call
- Number of calls placed on hold status
- Number of abandoned calls and the average abandoned time
- Average amount of time for each provider inquiry
- Agent Summary Report – daily information on individual phone representatives performance

For more information concerning this report view the *CentreVu Supervisor Guide Version 6* manual for details and descriptions of each type of report available.

Monthly Status Report

The Monthly Status Report is compiled for the purpose of contract monitoring for the State. The following reports provide detailed information for PRC-52, PRC-57, PRC-59, REC-28, and REC-29.

Table 5.2 – Reports

Report Title	Description
World Com	The Client Services High Level World Com monthly summary report for the Customer Assistance toll-free telephone line. This report includes weekend calls.
Monthly VDN Reports	CMS monthly VDN reports for the toll-free and local telephone numbers.
PRC-35B/REC-28B	This worksheet includes the detail information the “no more than 5 percent incoming calls can ring busy” requirement. This report does not include weekend calls.
PRC-35C/REC-28C	All splits combined report provides the detail information for “percentage answered with 120 seconds” requirement.
PRC-35D/REC-28D	This report includes detail information for the “average hold time must not exceed 30 seconds” requirement.
PRC-35E/REC-28E	This report includes detail information for the “call length is sufficient to ensure adequate information is imparted to caller” requirements

Section 6: Forms

Introduction

The following section includes all forms used by the CA analyst. Each form must be completed thoroughly including the CA analyst's name.

- Provider Enrollment Application Request Form
- EDS Internal Form Address Change
- Indiana Health Coverage Manual Request Form
- Provider Issue Inquiry Form (attach all necessary documentation)
- Written Inquiry Remittance Advice Form (attach address and check screens)
- Indiana Health Coverage Forms Request
- Stop Pay Request Form (attach address and check screens)
- EFT Request Form
- Referral Slip for Managed Care PMP

Copies of these forms can be found on L:/Client Services/CS CA Repository/Forms.

Provider Enrollment Application Request Form

Instructions: This form must be used for all enrollment application requests. Please answer all questions, write clearly, and use correct spelling to help ensure the applicant receives a Provider Enrollment Application in a timely manner. Begin this application by asking the provider what type of application is needed and if the provider previously participated in the Indiana Medicaid Program and received a provider number. If the provider has previously participated in Medicaid please ask for their original provider number and enter it on line 1.

Type of Application: (Circle One) 1. New Application 2. Re-enrollment
3. Additional Location 4. Change of Ownership 5. 590 Application

1. Please indicate previous provider number (if applicable or known): _____

2. Tax Identification Number or Social Security Number: _____

3. License Number: _____ Provider Type _____

4. Will the applicant be a group (e.g. billing provider), employed by a group (e.g. rendering provider or group member), or will the applicant be a sole proprietor (billing and rendering provider)? Circle one: 1. Group 2. Group member 3. Sole proprietor

5. Applicant's (individual or business) name: _____

6. Address application should be mailed to:

Street/P.O. Box _____ Suite/Floor _____

County _____ City _____ State _____ ZIP Code _____

7. Service location address (list physical location if different from above):

Street/P.O. Box _____ Suite/Floor _____

County _____ City _____ State _____ ZIP Code _____

8. Provider contact name and title the application will be addressed to:

Contact name: _____ Contact phone number: () _____

9. EDS intake representative's name _____ Date _____

Department _____ Phone number _____

EDS Internal Form ONLY

Address Information Change Request Form

Provider Number _____

Service Location _____

Group Tax ID: _____

OR

Physician License Number: _____

Service Location:

Business / Name

Street Address 1

City, State Zip

Phone Number

Mailing Address (Mail To)

****Bulletins, General Correspondence**

Business / Name

Street Address 1

City, State Zip

Phone Number

Payment Address (Pay To)

****Checks, Remittance Advice**

Business / Name

Street Address 1

City, State Zip

Phone Number

Home Office Address

Business / Name

Street Address 1

City, State Zip

Phone Number

Authorizing Officer _____

Title _____

Direct Phone Number _____

Date _____ Time _____

Analyst _____

Figure 6.2 – Address Information Change Request Form

INDIANA HEALTH COVERAGE PROGRAMS MANUAL REQUEST FORM							
_____ Initial Manual (No charge)	_____ Non-Provider / Additional Manual (Charge Paid)						
_____ Paper Manual Requested (Providers must state that they have no means of reading a CD - ROM)							
Provider Number: _____ Svc Loc: _____ Provider Type: _____							
Requested/New Provider Enrollment Date: _____ Circle One: CUST. ASST / PE / PFR							
Provider Name: _____	Phone Number: _____						
Street Address: _____	Zip Code: _____						
City: _____ State: _____	Analysts Name _____						
Attention: _____	Unit _____						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 60%;">Manual Type</th> <th style="text-align: left;">Provider (Specialty) Type</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">_____ Complete Provider Manual (370-PM1)</td> <td style="padding: 5px;">01 through 31</td> </tr> <tr> <td style="padding: 5px;">_____ ProDur Pharmacy</td> <td style="padding: 5px;">24 / 25</td> </tr> </tbody> </table>		Manual Type	Provider (Specialty) Type	_____ Complete Provider Manual (370-PM1)	01 through 31	_____ ProDur Pharmacy	24 / 25
Manual Type	Provider (Specialty) Type						
_____ Complete Provider Manual (370-PM1)	01 through 31						
_____ ProDur Pharmacy	24 / 25						
SPECIAL PROGRAMS							
_____ Home and Community Based Services Waiver Programs	State Approved 21(210,211),32						
_____ HealthWatch	01, 08(081, 082, 084, 085) 09(090, 092), 13(130) 31(316, 318, 322, 335, 345)						
_____ 590 Facility Manual Only	01(011), 13(130)						
_____ Hospice Manual **send all requests to Provider Enrollment**	06						
_____ MRO Manual	11(111)						
<p>*****Hoosier Healthwise*****Refer to the numbers listed below*****</p> <p>(PCCM) 1-800-889-9949 / (MHS) Northern Region - 1-800-414-9475 / Central & Southern Region - 1-800-360-6294 / Central Region - 1-800-356-1204</p>							
<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 2px solid black; padding: 10px; text-align: center; width: 40%;"> Mailroom use only: Date Mailed _____ </div> <div style="text-align: center; width: 50%;"> *RETURN TO PROVIDER ENROLLMENT QUALITY ASSURANCE </div> </div>							

Figure 6.3 – Indiana Health Coverage Manual Request Form

<h2>PROVIDER ISSUE INQUIRY</h2>	
<div style="border: 1px solid black; padding: 5px;"><p>DATE: _____ TIME: _____</p><p>INDIANA MEDICAID PROVIDER NUMBER: _____</p><p>PROVIDER NAME: _____</p><p>PROVIDER TELEPHONE NUMBER: _____ EXT: _____</p><p>NAME OF PERSON</p></div>	
<div style="border: 1px solid black; padding: 5px;"><p>ISSUE:</p><p>___ ADJUSTMENTS ___ ADVANCES ___ CLAIM COMPLETION ___ XOVERS</p><p>___ MEDICAL POLICY ___ PROCEDURE CODES ___ PROVIDER ENROLLMENT</p><p>___ RECIPIENT ELIGIBILITY ___ REMITTANCE ADVICE ___ PA ___ TPL</p><p>___ MANAGED CARE ___ STOP PAY/REISSUE ___ LOST DOCUMENTS</p><p>___ OTHER: _____</p></div>	
<div style="border: 1px solid black; padding: 5px;"><p>NATURE OF CALL: _____</p><p>_____</p><p>_____</p><p>_____</p><p>_____</p><p>_____</p><p>_____</p></div>	
<div style="border: 1px solid black; padding: 5px;"><p>PROVIDER ANALYST: _____</p><p>CALL-BACK: _____</p></div>	
<div style="border: 1px solid black; padding: 5px;"><p>RESOLUTION: _____</p><p>_____</p><p>_____</p><p>_____</p><p>_____</p><p>_____</p><p>_____</p></div>	

Figure 6.4 – Provider Issue Inquiry Form

Written Inquiry Remittance Advice Request Form

Limit one request per form
RA date must be greater than 14 days from today's date

Items in **Bold** are required fields and the request cannot be processed if empty.

Provider Number (include alpha location) _____

Provider Name: _____

Mailing Address: _____

This address must match the provider enrollment screen or have a notation indicating why it does not match. *Any changes in enrollment information should be submitted to Provider Enrollment.

Check or EFT # _____

This information must match the finance screen

Date of RA _____

This information must match the finance screen. Note that EFT's may occur any date during a three day span around the pay cycle. A RA cannot be mailed if requested within 14 days after the pay cycle. The provider should be directed to resubmit request if the RA does not arrive within 14 days.

Recipient ID# _____

ICN# _____

RID, Provider # and DOS (Date Of Service) must match payment date

Analyst Signature _____

Team Lead initials _____

This form will be forwarded to the Written Correspondence Unit. The RA will be mailed within 10 business days.

Form Number WCU 0001
Revision Date: 6/23/99

INDIANA HEALTH COVERAGE PROGRAMS MANUAL REQUEST FORM							
_____ Initial Manual (No charge)	_____ Non-Provider / Additional Manual (Charge Paid)						
_____ Paper Manual Requested (Providers must state that they have no means of reading a CD - ROM)							
Provider Number: _____	Srvc Loc: _____						
Provider Type: _____							
Requested/New Provider Enrollment Date: _____							
Circle One: CUST. ASST / PE / PFR							
Provider Name: _____	Phone Number: _____						
Street Address: _____	Zip Code: _____						
City: _____	State: _____						
Analysts Name _____							
Attention: _____	Unit _____						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 60%; padding: 5px;">Manual Type</th> <th style="text-align: left; width: 40%; padding: 5px;">Provider (Specialty) Type</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">_____ Complete Provider Manual (370-PM1)</td> <td style="padding: 5px;">01 through 31</td> </tr> <tr> <td style="padding: 5px;">_____ ProDur Pharmacy</td> <td style="padding: 5px;">24 / 25</td> </tr> </tbody> </table>		Manual Type	Provider (Specialty) Type	_____ Complete Provider Manual (370-PM1)	01 through 31	_____ ProDur Pharmacy	24 / 25
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SPECIAL PROGRAMS							
_____ Home and Community Based Services Waiver Programs	State Approved 21(210,211),32						
_____ HealthWatch	01, 08(081, 082, 084, 085) 09(090, 092), 13(130) 31(316, 318, 322, 335, 345)						
_____ 590 Facility Manual Only	01(011), 13(130)						
_____ Hospice Manual **send all requests to Provider Enrollment**	06						
_____ MRO Manual	11(111)						
<p>*****Hoosier Healthwise*****Refer to the numbers listed below*****</p> <p>(PCCM) 1-800-889-9949 / (MHS) Northern Region - 1-800-414-9475 /</p> <p>Central & Southern Region - 1-800-360-6294 / Central Region - 1-800-356-1204</p>							
<div style="display: flex; justify-content: space-between; align-items: flex-end;"> <div style="border: 2px solid black; padding: 10px; text-align: center; width: 30%;"> Mailroom use only: Date Mailed _____ </div> <div style="text-align: right; width: 60%;"> *RETURN TO PROVIDER ENROLLMENT QUALITY ASSURANCE </div> </div>							

Figure 6.6 – Indiana Health Coverage Forms Request

Eff 2/2/98

STOP PAY REQUEST

TO: Finance

FROM: _____

DATE: _____

SUBJECT: Stop Payment Request - Medicaid Check

NOTE: Stop Payment **will not** be processed until 7 working days after the check issue date.

REASON FOR STOP PAY: (check all that apply)

_____ Staledated Check Needs To Be Void

_____ Provider Lost Check

_____ Provider Didn't Receive Check/RA

_____ Copy of front and back _____ Date cashed

_____ Check Destroyed / Mutilated

_____ Other (Explain) _____

_____ Check is in house: **SEE ATTACHED**

*****PRINT CASH RECEIPT WINDOW IF CHECK IS IN HOUSE*****

CHECK INFORMATION:

Provider Number: _____ (verify # and location)

Provider Name: _____

Provider Address Change: _____ (verify)

Provider Phone Number: _____ (verify)

Check Amount: _____

Check Date: _____

Check Number: _____

PLEASE VERIFY that AIM has the correct address and phone number for provider. If there is an address change, forward to **PROVIDER ENROLLMENT** before sending to **FINANCE**.

Accounting Use Only:

_____ Check AIM

_____ Check Huntington View

_____ Voided

_____ Stopped in AIM _____ Stopped @ Bank

_____ Manual Replacement CK #

_____ System Replacement CK to be issued in next FIN cycle

Eff 10/27/00

Figure 6.8 – EFT Request Form

Instructions for Tracking/Referral Slip

1. Verify that the request for a certification code is from a Primary Care Case Management (PCCM) Primary Medical Provider (PMP). All other providers requesting certification codes must be referred to the member's PMP. Check the Provider Base screen in *IndianaAIM* – the PMP button will be highlighted if the provider is a PMP.
2. Note: RBMC PMPs do not receive certification codes.
3. Verify the correct provider address for the PMP service location listed in *IndianaAIM*. Certification code change letters are mailed to the service location of individual PMP providers if the provider is a PMP under a group. To determine if the provider is a PMP under a group or a PMP under an individual location, go to the Provider Base screen, open the PMP window and view all locations. If a group provider number is listed with the individual provider number, the PMP is under a group. The group provider number's service location is where the certification code letters are sent. Verify the group's service location address. If there is no group listed, the certification code letters will go to the service location listed for the individual provider number.)
4. If the address is correct in the system, complete the Tracking/Referral Slip and forward the issue to the Managed Care Unit.
5. If the address is incorrect in the system, have the providers contact their enrollment broker, AmeriChoice for PCCM or the MCO for RBMC, to update their enrollment records, requests for address change must be made in writing.

Tracking/Referral Slip For PCCM/PMP Providers Requesting Certification Codes	
Date _____	
PMP Provider Name _____	
Provider Number _____	Group Number _____
Provider Telephone Number _____	Fax# _____
Name of Caller _____	
Brief Description of Issue _____	

Is the address <u>Correct</u> in AIM (see step 2 of instructions)? Please check	
<input type="radio"/>	<input type="radio"/>
Yes	No

Figure 6.9 – Referral Slip for Managed Care PMP

Performance Standards

Overview

This section lists the performance standards the Customer Assistance Unit is required to meet in accordance with the IHCP agreement effective January 1, 2004.

RFP Requirements

PRC – 31

Staff provider relations and member hotline toll free phone lines (for Indiana and the contiguous states) from 8 a.m. to noon and 1 p.m. to 5 p.m., Indianapolis local time, Monday through Friday, excluding State holidays.

PRC – 32

Maintain a sufficient number of telephone lines and personnel to staff so that:

- Ninety-five percent of all calls are answered on or before the fourth ring.
- No more than five percent of incoming calls can ring busy.
- A live person must answer 95 percent of calls that are answered within two minutes. Hold time must not exceed two minutes.
- The average hold time is 30 seconds under normal business activities. Communicate to the State exceptions to this target.
- Call length is sufficient to ensure adequate information is imparted to the caller.
- Services are available in both English and Spanish.

PRC – 33

Obtain State approval prior to limiting the number of topics that can be addressed by the caller.

PRC – 34

Provide reports to monitor compliance with the above requirements.

PRC – 46

Supply and staff toll-free telephone lines (for Indiana and contiguous states) for provider and member inquiries concerning enrollment, billing, covered services, or claim payment. The staff that performs these functions shall be specialized to respond to the specific needs of particular provider types or specialties. While cross training is also necessary, specialists with a more thorough understanding of a specific provider type or specialty needs will provide more knowledgeable and accurate information to providers.

PRC – 48

Develop a training program and materials, and update as necessary, to ensure that all provider services staff are equipped to supply accurate, complete, and consistent answers to provider inquiries. Staff shall have access to necessary supporting documentation and shall have a thorough understanding of provider issues to ask relevant questions and understand all areas that are impacted by provider's inquiry. The contractor must ensure supporting documentation is updated on a regular basis and staff is informed of any changes.

PRC – 51

Maintain an automated system for tracking and reporting written and telephone inquiries that ensure online retrieval of the date and nature of the inquiry, provider name and number, and the date and nature of the reply.

PRC – 52

Provide the State with monthly reports showing the timeliness of responses to all provider inquiries received by the toll-free phone lines, local calls received, and written inquiries.

PRC – 56

Maintain a history of inquiries made by providers and the inquiry responses. Detailed information must be maintained online for a period of three months. Summary information must be stored in *COLD Solutions* (On-Demand) for a period of five years.

PRC – 57

Provide the State with separate monthly reports on all calls placed by providers and IHCP members to the Provider Relations Unit, member 800 lines, local calls, and the timeliness of written correspondence for the prior month's activity. The reports should include information on busy rates, number of calls, a summary of the type of call, the provider that made the call, and other information to monitor contractor responsiveness. The reports shall be submitted within five business days of the end of the reporting month.

PRC – 58

Provide the State with monthly qualitative and quantitative reports summarizing all calls answered and timeliness of written correspondence, according to State specifications. The reports should include information on the provider types, types of calls, and other information.

PRC – 59

Supply phone company reports of all line activities, busy signals, hang-ups, and nonconnects as well as internal reports of hold time, percentage of calls answered within 120 seconds, and the number of calls answered.

PRC – 60

Supply providers with HCPCS code listings, narratives, and updates upon provider request. Information will be available on the IHCP Web site. If requested by providers, the information must be available in a hardcopy format.

REC – 26

Maintain toll-free telephone lines for Indiana and the contiguous states for member inquiries, referred to as the member hot line, and personnel to staff the lines so that:

- Ninety-five percent of all calls answered on or before the fourth ring.
- No more than five percent of incoming calls ring busy.
- A live person must answer 95 percent of all calls that are answered within two minutes.
- The average hold time does not exceed 30 seconds.
- Call length is sufficient to ensure adequate information is imparted to the caller.
- The contractor must obtain State approval prior to limiting the number of topics that can be addressed by the caller.

REC – 27

Staff member hotline toll-free lines from 8 a.m. to noon and 1 p.m. to 5 p.m., local time, Monday through Friday, excluding State holidays.

REC – 28

Provide reports to monitor compliance with the telephone performance requirements.

REC – 29

Provide reports that capture member inquiries to the hotline by subject and number of inquiries.

REC – 31

Department/Unit: Customer Assistance

Performance Standard

- Provide reports that capture member inquiries to the hotline by subject and number of inquiries.

Operational Definition

The-system administrator obtains a printed copy of all the monthly reports. This includes the following: high level summary of the total calls received for all provider phone lines, PRVMPHON-3 report, Avaya, and Time Warner reports, and all CMS reports. The supervisor or team lead completes

a check sheet developed to ensure all reports are included with a cover letter prior to sending the monthly packet to the director of OMPP program operations.

REC – 32

Department/Unit: Customer Assistance

Performance Standard

- Provide reports that monitor timeliness of telephone hotline responses.

Operational Definition

The system administrator obtains a printed copy of all the monthly reports. This includes the following: high level summary of the total calls received for all provider phone lines, *PRVMPHON-3* report, Avaya, and Time Warner reports, and all CMS reports. The supervisor or team lead completes a check sheet developed to ensure all reports are included with a cover letter prior to sending the monthly packet to the director of OMPP program operations.

Section 7: New Employee Training Schedule

Knowledgeable staff is critical to providing superior service to provider and members. The customer assistance supervisor is responsible for presenting a comprehensive training program that includes all aspects of the IHCP and the policies that govern the providers rendering services. The customer assistance supervisor delegates this authority to the customer assistance trainer. This customer assistance trainer is responsible for design and implementation of training not only new employees, but the on-going training and development of existing staff.

Listed below is the new employee-training schedule. This training program is a 10-week program that combines theory with practical application.

Week 1

Day 1

- Security access – entrance to work area
- Parking pass
- Security access – computer system
- Organizational overview
- New employee orientation session – schedule with administrator
- Employees are recorded for three hours per quarter
- Administrative processes
- Protected Health Information (PHI) training
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- New employee will spend the entire day in the mailroom.

Day 3

- New employee will spend the entire day in the Data Entry Unit.

Day 4

- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 5

- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.
- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and employee self service (ESS), if day five is on Friday.

Week 2

Day 1

- Read chapter 1 of the *IHCP Provider Manual*.
- Complete chapter 1 Study Guide.
- Review chapter 1 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- Review chapter 1 of the *IHCP Provider Manual*
- Read chapter 2 of the *IHCP Provider Manual*
- Complete chapter 2 Study Guide.
- Review chapter 2 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 3

- Review chapter 2 of the *IHCP Provider Manual*
- Read chapter 3 of the *IHCP Provider Manual*
- Complete chapter 3 Study Guide.
- Review chapter 3 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 4

- Review chapter 3 of the *IHCP Provider Manual*
- Read chapter 4 of the *IHCP Provider Manual*

- Complete chapter 4 Study Guide.
- Review chapter 4 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 5

- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and ESS if day five is on Friday.
- Review chapters 1 thru 4 of the *IHCP Provider Manual*
- Review chapters 1 through 4 with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Week 3

Day 1

- Read chapter 5 of the *IHCP Provider Manual*
- Complete chapter 5 Study Guide.
- Review chapter 5 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- Review chapter 5 of the *IHCP Provider Manual*.
- Read chapter 6 of the *IHCP Provider Manual*.
- Complete chapter 6 Study Guide.
- Review chapter 6 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 3

- Review chapter 6 of the *IHCP Provider Manual*.
- Read chapter 7 of the *IHCP Provider Manual*.
- Complete chapter 7 Study Guide.

- Review chapter 7 and Study Guide with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 4

- Review chapter 7 of the *IHCP Provider Manual*.
- Read chapter 8 of the *IHCP Provider Manual*, focusing on the UB-92 claims.
- Complete chapter 8 Study Guide.
- Review chapter 8 and Study Guide, focusing on the UB-92 claims, with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 5

- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and ESS, if day five is on Friday.
- Review chapter 1 thru 7 of the *IHCP Provider Manual*.
- Review chapter 8 of *IHCP Provider Manual*, focusing on the UB-92 claims with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Week 4

Day 1

- Review chapter 8 of the *IHCP Provider Manual*, focusing on the UB-92 claims.
- Read chapter 8 of the *IHCP Provider Manual*, focusing on the CMS-1500 claim form.
- Complete chapter 8 Study Guide.
- Review chapter 8 and Study Guide, focusing on the UB-92 claims, with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- Review chapter 8 of the *IHCP Provider Manual*, focusing on the UB-92 claims.

- Read chapter 8 of the *IHCP Provider Manual*, focusing on the CMS-1500 claims.
- Review chapter 8 of the *IHCP Provider Manual*, focusing on the CMS-1500 claims.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 3

- Review chapter 8 of the *IHCP Provider Manual*, focusing on the UB-92 claims.
- Read chapter 8 of the *IHCP Provider Manual*, focusing on the CMS-1500 claims.
- Review chapter 8 of the *IHCP Provider Manual*, focusing on the CMS-1500 claims with the customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 4

- Review chapter 8 of the *IHCP Provider Manual*, focusing on the UB-92 and CMS-1500 claims.
- Read chapter 8 of the *IHCP Provider Manual*, focusing on the dental claims.
- Complete chapter 8 Study Guide.
- Review chapter 8 and Study Guide, focusing on the dental claims, with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 5

- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and ESS, if day five is on Friday.
- Spend the day with the dental subject matter expert (SME).

Week 5

Day 1

- Review Chapter 8 of the *IHCP Provider Manual*, focusing on the dental claims.
- Review chapter 8 of the *IHCP Provider Manual*, focusing on the dental claims with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- Review chapter 8 of the *IHCP Provider Manual*, focusing on the dental claim form.
- Read chapter 8 of the *IHCP Provider Manual*, focusing on informed consent and HCPCS.
- Review chapter 8 of the *IHCP Provider Manual* focusing on informed consent and HCPCS with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 3

- Review chapter 8 of the *IHCP Provider Manual* focusing on informed consent and HCPCS.
- Read chapter 9 of the *IHCP Provider Manual*.
- Review chapter 9 of the *IHCP Provider Manual*, with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 4

- Review chapter 9 of the *IHCP Provider Manual*.
- Review chapter 9 of the *IHCP Provider Manual*, with customer assistance trainer.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 5

- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and ESS, if day five is on Friday.
- Review chapters 8 and 9 of the *IHCP Provider Manual*, focusing on all portions covered in training.
- New employee will spend time with the customer assistance trainer listening to incoming calls. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Week 6**Day 1**

- Read chapter 10 of the *IHCP Provider Manual*.
- Complete chapter 10 Study Guide.
- Review chapter 10 and Study Guide, with customer assistance trainer.

- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- New employee will spend the entire day in the Resolution Unit.

Day 3

- Review chapter 10 of the *IHCP Provider Manual*.
- Read chapter 11 of the *IHCP Provider Manual*.
- Complete chapter 11 Study Guide.
- Review chapter 11 and Study Guide, with customer assistance trainer.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 4

- New employee will spend the entire day in the Adjustment Unit.

Day 5

- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and ESS, if day five is on Friday.
- Review chapter 11 of the *IHCP Provider Manual*.
- Read chapter 12 of the *IHCP Provider Manual*.
- Complete chapter 12 Study Guide.
- Review chapter 12 and Study Guide, with customer assistance trainer.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Week 7

Day 1

- Review chapters 8 thru 12 of the *IHCP Provider Manual*.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 2

- New employee will study PHI.
- Review chapter 12 of the *IHCP Provider Manual*.
- Read chapter 13 of the *IHCP Provider Manual*.
- Complete chapter 13 Study Guide.
- Review chapter 13 and Study Guide, with customer assistance trainer.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 3

- Read, study, and review PHI.
- Review chapter 13 of the *IHCP Provider Manual*.
- Complete chapter 13 Study Guide.
- Review chapter 13 and Study Guide, with customer assistance trainer.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 4

- New employee will take the PHI test.
- Review chapter 14 of the *IHCP Provider Manual*.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Day 5

- The customer assistance trainer will ensure that the new employee has entered their time in US time tracking and ESS, if day five is on Friday.
- Review chapter 14 of the *IHCP Provider Manual*.
- Read the Appendix of the *IHCP Provider Manual*
- Review the Appendix of the *IHCP Provider Manual* with customer assistance trainer, and answer questions on study guide.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Week 8

Day 1

- Review chapters 8 thru 14 of the *IHCP Provider Manual*.
- New employee will answer member calls, while the customer assistance trainer listens and observes. The customer assistance trainer will discuss information between calls and review questions, if call volume permits.

Days 2 thru 5

- New employee will answer member and provider calls, while the customer assistance trainer listens and observes.

Week 9

- New employee will answer member and provider calls, while the customer assistance trainer listens and observes.

Week 10

- New employee will answer member and provider calls, while the customer assistance trainer listens and observes.

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who will obtain confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

- 1115(a)** Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Health Care Financing Administration, Waiver*.
- 11971** State form 11971; see 8A.
- 1261A** Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*
- 1500** This is a claim form used by participating Indiana Health Coverage Programs (IHCP) providers to bill medical and medically related services. See also *CMS-1500*.
- 1902(a)(1)** Section of the Social Security Act that requires state Medicaid programs be in effect “in all political subdivisions of the state”. See also *Statenewness*.
- 1902(a)(10)** Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.
- 1902(a)(23)** Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver*.
- 1902(r)(2)** Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.
- 1903(m)** Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.
- 1915(a)** Section of the Social Security Act that states requirements for Medicaid.
- 1915(b)** Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also <i>CLASS, HCS, MDCP, CMS, NF, Waiver</i> .
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also <i>CMS, HCS-O, Waiver</i> .
1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also <i>Home and Community Care</i> .
450A	Social Evaluation for Long Term Care Admission
450B	Certification by Physician for Long Term Care Services.
590 Program	A State health coverage program for institutionalized persons under the jurisdiction of the Division of Mental Health and Department of Health.
7748	State Form 7748, Medicaid Financial Report
8A	<i>DPW Form 8A (State Form 11971), Notice to Provider of Member Deductible.</i> Used to relay member spend-down information to providers when the date of service is the same as the spend-down met date.
AA	Anesthesia Assistant.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAC	Alternative or Augmentative Communication device.
AAP	American Academy of Pediatrics.
AAS	Atomic absorption spectrophotometer.
ABA	American Banking Association.
ABG	Arterial blood gas.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.

ACOG	American College of Obstetricians and Gynecologists.
ACS	Affiliated Computer Services. State Healthcare PBM. Pharmacy Benefits Manager, Drug Rebate Services.
ACSW	Academy of Certified Social Workers.
ADA	American Dental Association.
ADAP	AIDS Drug Assistance Program.
ADC	Adult day care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
ADL	Activities of daily living.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children is replaced by Temporary Assistance to Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance IHCP members, who are 65 years old or older, or IHCP members under any other category who are entitled to benefits under Medicare.
AHF	Antihemophiliac factor.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act. Replaced by Temporary Assistance to Needy Families (TANF).
Aid to the Blind (AB)	A classification or category of IHCP members eligible for benefits under the IHCP.
AIDS	Acquired Immune Deficiency Syndrome.
AIM	Advanced Information Management.

ALJ	Administrative Law Judge.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ALS	Advanced life support.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARC	Association of Retarded Citizens.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
Attending Physician	The physician providing specialized or general medical care to a member.
Auditing Contractor	The entity under contract with the Office of Medicaid Policy and Planning (OMPP) to conduct audits of long-term-care facilities or other functions and activities as designated by OMPP.
auto assignment	IndianaAIM process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning member eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.

sAverage Wholesale Price; used in reference to drug pricing.	IndianaAIM process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavioral health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	A statement of charges for medical services, the submitted claim document, or electronic record; which may contain one or more services performed.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP member.
billing service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
BLS	Basic Life Support.
Blue Book	The <i>American Druggist Blue Book</i> , used as a reference in pricing drug products.

Boren Amendment	An amendment to <i>OBRA 80 (P.O. 96-499)</i> , which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were “reasonable and adequate” to meet the costs of “efficiently and economically operated” providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
BQAMIS	Bureau of Quality Assurance Management Information System.
BSN	Bachelor of Science in Nursing.
BSW	Bachelor of Social Work.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of IHCP services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits and procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP members, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal; a document from the Indiana State Department of Health (ISDH).
C519	Authorization for Member Liability Deviation, generated by the Medicaid member’s county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given member per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
CARF	Commission on Accreditation of Rehabilitation Facilities
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.

Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP member is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by IndianaAIM and sent to the provider that submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CCSW	Certified Clinical Social Worker.
CDC	Centers for Disease Control.
CDFC	County Division of Family and Children.
CDPW	County Department of Public Welfare, which is changed to the County Offices of the Division of Family and Children.
CDT	Current Dental Terminology.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM IHCP members to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family IHCP members, military retirees and family IHCP members of military retirees, now known as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CHIP	Children's Health Insurance Program.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for IHCP claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP.
Cm	Centimeter.
CMHC	Community Mental Health Center.
CMI	Case Mix Index.
CMN	Certificate of Medical Necessity.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
COB	Coordination of benefits.

co-insurance	The portion of Medicare-determined allowed charge that a Medicare member is required to pay for a covered medical service after the deductible has been met. The co-insurance or a percentage amount is paid by IHCP if the member is eligible for Medicaid. See also <i>Cost Sharing</i> .
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also <i>ICF MR, 1915(c), Waiver</i> .
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP members certifying that they give “informed consent” for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor	<p>Offeror with whom the State successfully negotiated a contract pursuant to <i>IC 12-1-7-17</i>.</p> <p>Auditing Contractor – The entity under contract with the OMPP to conduct audits of long-term-care facilities or other functions and activities as designated by the OMPP.</p> <p>Fiscal Agent Contractor – The offeror(s) with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.</p> <p>Rate-Setting Contractor – Entities under contract with the OMPP to perform rate-setting activities for hospitals and long-term-care facilities.</p>
conversion factor	Number that when multiplied by a particular procedure code’s relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
copayment or copay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also <i>Cost Sharing</i> .

core contractor	The successful bidder on <i>Service Package #1: Claims Processing and Related Services</i> .
core services	Refers to <i>Service Package #1: Claims Processing and Related Services</i> .
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP members subject to the limitations of the <i>Indiana Administrative Code</i> (IAC).
CP	Clinical psychologist.
CPAS	Claims processing assessment system. An automated claims analysis tool used by the State for contractor quality control reviews.
CPM	Continuous Passive Motion.
CPS	Child Protective Services.
CPT	Current Procedural Terminology.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central Processing Unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.

CRLD	Computer report to laser disk.
CRNA	Certified Registered Nurse Anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to IHCP benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS IHCP members do not have to be IHCP-eligible. If they are also eligible for the IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Certified Social Worker
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP program, including State staff, IHCP members, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
CVP	Central venous pressure.
D&E	Diagnostic and evaluation (in reference to services and providers).
DASS	Delivery and Support System.
data element	A specific unit of information having
DC	Doctor of Chiropractic.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
DDE	Direct data entry.
DDS	Doctor of Dental Surgery.
deductible	Fixed amount that a Medicare member must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug Efficacy Study and Implementation, drug determined to be less than effective (LTE); not covered by the IHCP.
designee	A duly authorized representative of a person holding a superior position.

detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also <i>Mental Retardation, Related Condition</i> .
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through CMS.
DHS	Department of Human Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also <i>ICD-9-CM, DRG</i> .
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DMHA	Division of Mental Health and Addictions.
DO	Doctor of Osteopathy.
DOB	Date of birth.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Family and Social Services Administration
DPW Form 8A	See 8A.

DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
drug code	Code established to identify a particular drug covered by the IHCP.
Drug Efficacy Study and Implementation (DESI)	A drug determined to be less than effective (LTE) and not covered by the IHCP.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series number is usually associated with the acronym.
DSS	Decision Support System. A data extraction tool used to evaluate IHCP data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
E/M	Evaluation and Management.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phone lines to IndianaAIM. ECC uses point-of-sale devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; most commonly, long-term care (LTC); or nursing home (NH), or nursing facility (NF).
ECM	Electronic claims management; overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, and paperless claims.
ECS	Electronic claims submission. Claims submitted in electronic format rather than paper. See <i>ECC</i> , <i>EMC</i> .
EDI	Electronic data interchange.
EDP	Electronic data processing.
EDS	Electronic Data Systems Corporation, the IHCP claims processing and third party liability contractor.

EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EIP	Early Intervention Program
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible member	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See <i>ECC</i> , <i>ECS</i> .
EMS	Emergency medical services.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by IndianaAIM and sent to IHCP members. The EOMB details the payment or denial of claims submitted by providers for services provided to IHCP members. See also <i>MRN</i> .
EOP	Explanation of payment, term previously used by the IHCP for the claim summary statement – currently know as a remittance advice (RA). Other insurers continue to use the term for claim statements to providers.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for IHCP-eligible IHCP members younger than 21 years old offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also <i>Rejected Claim</i> .
ESRD	End Stage Renal Disease.

EST	Eastern Standard Time, which is also Indianapolis local time, is a constant in <i>the majority</i> of the state of Indiana. This means that from the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing Central Standard Time (CST), like Chicago. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing Eastern Standard Time (EST), like New York. This is because Indiana does not observe daylight savings time.
EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also <i>Preferred Provider Organization</i> .
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
FDB	First DataBank.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also <i>Indemnity Insurance</i> .
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FFS	Fee-for-service.
FID	Federal Investigation Database.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal Agent Contractor	The offeror with whom the State successfully negotiated a contract to perform one or more business functions associated with claims processing and provider payment activities.

fiscal month	Monthly time interval in a fiscal year.
Fiscal Year	The designated annual reporting period for an entity: State of Indiana – July 1 through June 30 Federal – October 1 through September 30 Fiscal intermediary shared system.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, <i>Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility</i> .
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
FTE	Full time employee.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
GCN*SEQND	Generic code sequence number classification system.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.

Gm	Gram.
GPCI	Geographic practice cost index.
GPCPD	Governor's Planning Council for People with Disabilities.
GPI	Generic pricing indicator.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as "paper" and "manual".
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged IHCP members to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel, Inc. The IHCP prior authorization, surveillance and utilization review and medical policy contractor
HCFA-1500	CMS-approved standardized claim form used to bill professional services. Now referred to as CMS-1500.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	Healthcare Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana's preventive care program for IHCP IHCP members younger than 21 years old. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.

HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC	Health insurance carrier number.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health insurance premium payments.
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organization.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also <i>Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management</i> .
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also <i>Section 1919, Primary Home Care</i> .
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under <i>Section 1915(c)(7)(b)</i> of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also <i>Section 1915(c)(7)(b), PASARR, Waiver</i> .

Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound IHCP members by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	Hoosier Healthwise is an IHCP managed care program that consists of two components including Primary Care Case Management (PCCM) and risk-based managed care (RBMC).
HOPA	Hospital outpatient area.
HPB	Health Professions Bureau.
HPSA	Health professional shortage area.
HPSB	Health Professions Service Bureau.
HRI	Health-related items.
HRR	High risk register (in relation to audiological screening).
HSA	Home service agency.
HSPP	Health services provider in psychology.
IAC	<i>Indiana Administrative Code – Indiana rules.</i> State government agency administrative procedures.
IC	Indiana Code – Indiana laws.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for IHCP-eligible, mentally retarded individuals.
ICHIA	Indiana Comprehensive Health Insurance Association, a health insuring organization for special situations.
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.

IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEMS	Indiana Emergency Medical Service.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IHCP	Indiana Health Coverage Program.
IMCA	Indiana Motor Carrier Authority.
IMCS	Indiana Motor Carrier Services.
IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also <i>Fee-for-Service</i> .
Indiana Family and Social Service Administration (IFSSA)	The State agency responsible for the coordination and administration of social service programs in the state of Indiana. The OMPP, under Indiana Family and Social Security Administration (IFSSA), is the single State agency responsible for the administration of the IHCP.
Indiana State Department of Health (ISDH)	The State agency responsible for promotion of health; providing guidance on public health issues; ensuring the quality of health facilities and programs and the administration of certain health programs. The Bureau of Family Health Services is the bureau within the Indiana State Department of Health (ISDH) organization charged with the administration of the Children's Special Health Care Services Division (CSHCS) as well as the Maternal and Child Health Division (MCH) and the Division of Women, Infants, and Children (WIC).
IndianaAIM	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).

inquiry	Type of online screen programmed to display rather than enter information. Used to research information about IHCP members, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPAS	Indiana Pre-Admission Screening.
IPP	Individualized Program Plan.
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health; currently known as the Indiana State Department of Health.
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of IndianaAIM used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.

Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
L	Liter.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
LCN	Letter control number.
LCSW	Licensed Clinical Social Worker.
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
LLP	Limited license practitioner.
LMFT	Licensed Marriage and Family Therapist.
LMHC	Licensed Mental Health Counselor.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed Practical Nurse.
LSL	Lower specification limit, pertains to quality control charts.
LSW	Licensed Social Worker.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to IHCP members.
LTE	Less than effective drugs.

M/M	Medicare/Medicaid.
MAC	Maximum allowable cost for drugs as specified by the federal government.
MAC	Monitored anesthesia care
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also <i>Section 1915(b)</i> , <i>HMO</i> , <i>PPO</i> , <i>Primary Case Management</i> .
Managed Care PCCM	IHCP members in the primary care case management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the IHCP members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
Managed Care RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of IHCP members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSTD (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as <i>paper</i> and <i>hard copy</i> .
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of IndianaAIM that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also <i>HMO</i> , <i>Prepaid Health Plan</i> .
MCPD	A pilot program that was available in Marion county from January 1997 through December 1999. It was a voluntary risk-based managed care program for IHCP enrollees that were considered disabled or chronically ill according to the State's established criteria.
MCS	Managed Care Solutions (now called Lifemark Corporation).
MD	Medical Doctor.
MDS	Minimum data set.

Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a member's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also <i>Medicaid State Plan, Single State Agency</i> .
Medicaid Select	A managed care program for the aged, blind and disabled population consisting of a Primary Care Case Management (PCCM) delivery system.
Medicaid State plan	See also <i>Single State Agency, Medicaid Plan</i> .
Medicaid-Medicare eligible	Member who is eligible for benefits under both Medicaid and Medicare. IHCP members in this category are <i>bought-in</i> for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the State for the IHCP.
medical policy contractor	Successful bidder on <i>Service Package #2: Medical Policy and Review Services</i> .
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.

Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A or Part B for services authorized by Medicare Part A or Part B.
member	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP members. These individuals are called enrollees or IHCP members when in the Hoosier Healthwise Program. See also <i>Client, Eligible Member</i> .
member relations	The activity within the single state agency that handles all relationships between the IHCP and individual member.
member restriction	A limitation or review status placed on a member that limits or controls access to the IHCP to a greater extent than for other nonrestricted IHCP members.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the <i>American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders</i> .
mental retardation	Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
MHS	Managed Health Services.
MI	Mental illness.
MI/DD	Mental illness and developmental disability.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral.
misutilization	Any usage of the IHCP by any of its providers or IHCP members not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
ml	Milliliter.
MLOS	Mean Length of Stay.

MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as <i>IndianaAIM</i> .
MMRT	Medicaid Medical Review Team.
MOC	Memorandum of Collaboration; a Hoosier Healthwise document that provides a formal description of the terms of collaboration between the primary medical provider (PMP) and the preventive health care service provider (PHCSP). It also serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MR/DD	Mental retardation and developmentally disabled.
MRN	Medicare Remittance Notice. A form provided by <i>IndianaAIM</i> and sent to IHCP members. The MRN details the payment or denial of claims submitted by providers for services provided to IHCP members.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team, unit which makes decision regarding Disability Determination.
MS	Mail stop.
MSN	Master of Science in Nursing.
MSS	Master of Social Sciences.
MSW	Master of Social Work.
MWU	Medicaid Waiver Unit, the IDDARS unit which manages the HCBS Waiver Programs.
NAS	Non-ambulatory service.
NASW	National Association of Social Workers.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.

NDDF	National Drug Data File.
NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO IHCP members.
NF	Nursing facility; also seen as ECF, NH, and LTC.
NH	Nursing home; also seen as ECF, NF, and LTC.
NIH	National Institutes of Health.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to <i>Service Packages #2 and #3</i> .
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the <i>Federal Register</i> on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the State in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also <i>Long Term Care, TILE</i> .
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also <i>Nursing Facilities, 1915(c), Waiver</i> .
OASDI	Old Age, Survivors and Disability Insurance. See also <i>Title II Benefits (Social Security or OASDI)</i> .
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act.
OBRA-90	Omnibus Budget Reconciliation Act of 1990.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.

OD	Doctor of Optometry.
OFC	Office of Family and Children.
OIG	Office of the Inspector General.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter, in reference to drugs.
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs IHCP functions under the direction of the single state agency. The single state agency may perform all IHCP functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a IHCP member from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a IHCP member resulting from the failure of the contractor to use available information or to process correctly.

override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated IHCP services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by the IHCP.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by IHCP that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as <i>hard copy</i> and <i>manual</i> .
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also <i>Medicare, Beneficiary</i> .
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also <i>Medicare, SMIB, Buy-In</i> .
participant	One who participates in the IHCP as either a provider or a member of services.
participating IHCP members	Individuals who receive Title XIX services during a specified period of time.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the State that specifies the conditions and the services the facility must provide to serve IHCP IHCP members and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a member's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.

PAS Form 4B	Pre-Admission Screening Notice of Assessment Determination form.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PC	Personal computer.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	IHCP members in the Primary Care Case Management delivery system are linked to a primary medical provider (PMP) that acts as a gatekeeper by providing and arranging for most of the IHCP members' medical care. The PMP receives an administrative fee per month for every member and is reimbursed on a fee-for-service basis.
PCN	Primary care network.
PCP	Primary Care Provider.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
PEN	Parenteral and enteral nutrition .
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device which enables the consumer to secure help in an emergency.

personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also <i>Primary Home Care</i> .
PET	Positron Emission Tomography.
PGA	Peer group average.
PHC	Primary home care. IHCP-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional State plan benefit. See also <i>Personal Care</i> .
PHCSP	Preventive health care services provider; a provider of well-child care, pre-natal care services, or care coordination services.
PHO	Physician hospital organization.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also <i>VISTA</i> .
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating IHCP members of the hospital's medical staff.
PKU	Phenylketonuria.
Plan of Care	A formal plan developed to address the specific needs of an individual. It links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMF	Provider master file.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to IHCP IHCP members assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed x level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also <i>Exclusive Provider Organization (EPO)</i> .

PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
Premium	Due from member in order to be eligible for Package C.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.
prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
Prior Authorization or Prior Review and Approval	The procedure for the office's prior review and authorization, modification, or denial of payment for covered medical services and supplies within IHCP allowable charges. It is based on medical reasonableness, necessity, and other criteria as described in the <i>IAC Covered Services Rule</i> and <i>Medical Policy Rule</i> found in the <i>Appendix</i> to this manual.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also <i>Adjudicated Claim</i> .
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.

profile	Total view of an individual provider's charges or a total view of services rendered to a member.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that is enrolled as a provider of services and provides a covered IHCP service to an IHCP member.
Provider Agreement	A contract between a provider and the OMPP setting out the terms and conditions of a provider's participation in the IHCP. It must be signed by the provider prior to any reimbursement for providing covered services to IHCP members.
provider enrollment application	Required document for all providers who provide services to IHCP IHCP members.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor or dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.

QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by IndianaAIM explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
Rate-Setting Contractor	An entity under contract with the OMPP to perform rate-setting activities.
RBA	Room and Board Assistance.
RBMC	In a risk-based managed care delivery system, the OMPP pays contracted managed care organizations (MCOs) a capitated monthly premium for each IHCP enrollee in the MCO's network. The care of IHCP members enrolled in the MCO is managed by the MCO through its network of PMPs, specialists and other providers of care, who contract directly with the MCO.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by the OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a member to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reimbursement	Payment made to a provider, pursuant to Federal and State law, as compensation for providing covered services to IHCP members.

reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also <i>Stop-Loss Insurance</i> .
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the member disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Retrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic
RID	Member Identification (ID) number; the unique number assigned to a member who is eligible for IHCP services.

risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also <i>MCO, Pool, Risk Pool</i> .
RN	Registered Nurse.
RNC	Registered Nurse Clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment.
RPT	Registered physical therapist.
RPTS	Research Project Tracking System.
RR	Resident review.
RUG	Resource Utilization Group.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
RVU	Relative value unit.
SA/DE	State Authorization/Data Entry.
SBOH	State Board of Health; previous term for the State Department of Health.
SCP	Specialty care physicians.
screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
SED	Seriously emotionally disturbed.
SEH	Seriously emotionally handicapped.
selective contracting	Option under Section 1915(b) of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.

service date	Actual date on which a service(s) was rendered to a particular member by a particular provider.
service limits	Maximum number of service units to which a member is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers
SI/IS	Severity of illness/intensity of services.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Severely mentally ill.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Sixth Omnibus Budget Reconciliation Act.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
Spend-down	Process whereby IHCP eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.

SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash assistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor.
Staff Model HMO	Health care model that employs physicians to provide health care to its IHCP members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	Spelled as shown, State refers to the state of Indiana and any of its departments or agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Form 11971	See 8A.
State Form 7748	Medicaid Financial Report, used for cost reporting.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the IHCP in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pending, denied, and so forth.

stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as \$25,000 or \$50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125 percent of the amount expected in an average year. See also <i>Reinsurance</i> .
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: member's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.
SUR	<p>Surveillance and Utilization Review. Refers to system functions and activities mandated by the Centers for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR</p> <ul style="list-style-type: none"> ◆ Statistical analysis ◆ Exception processing ◆ Provider and member profiles ◆ Retrospective detection of claims processing edit and audit failures and errors ◆ Retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards ◆ Retrospective detection of fraud and abuse by providers or IHCP members ◆ Sophisticated data and claim analysis including sampling and reporting ◆ General access and processing features ◆ General reports and output
Survey Agency	The ISDH is the designated survey agency responsible for surveying, monitoring, reviewing, and certifying institutional providers of service who request or agree to participate in the IHCP. The ISDH also certifies several other provider types. These types are discussed under the section titled; <i>State, County Contractor Responsibilities</i> included in this chapter.
suspended transaction	A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).
suspense file	Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems CA analyst or engineer	<ul style="list-style-type: none"> ◆ Detailed system and program design ◆ System and program development ◆ Maintenance and modification analysis and resolution ◆ User needs analysis ◆ User training support ◆ Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. A replacement program
TBI	Traumatic brain injury.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or member of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.

Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all IHCP members to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirements of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the IHCP members to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to Service Package #3: Third-Party Liability and Drug Rebate Services.
TPN	Total Parenteral Nutrition.
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
TRICARE	Formerly known as the Civilian Health and Medical Plan for the Uniformed Services (CHAMPUS); health-care plan for active duty family IHCP members, military retirees, and family IHCP members of military retirees.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
UM	Utilization management.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.

UPC	Universal product code. Codes contained on the first data bank tape update or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
USPHS	United States Public Health Service.
utilization	The extent to which the IHCP members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VA	Veterans Administration.
VFC	Vaccines for Children program.
VIP	Validation Improvement Plan.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
waiver	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.
WIC	Year 2000. Commonly used in computer system compliance issues.

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